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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/05/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left L5-S1 Epidural Steroid Injection #3

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Pain Medicine

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.
Given the current clinical data, it is the opinion of the reviewer that the requested Left L5-S1 Epidural Steroid Injection #3 is not indicated as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 05/04/12, 06/14/12
Office visit note dated 06/05/12-02/16/11
MRI lumbar spine dated 04/15/11, 02/22/12
Letter dated 06/15/12

PATIENT CLINICAL HISTORY [SUMMARY]
The patient is a male whose date of injury is xx/xx/xx. On this date the patient was turning a reel of wire and felt a snap in his left lower back. He had physical therapy and improved quite a bit. A note dated 02/07/12 indicates that the patient previously had epidural steroid injections with Dr., and that was extremely helpful. MRI of the lumbar spine dated 02/22/12 revealed L5-S1 disc protrusion/herniation contributes to moderate left foraminal stenosis with contact on left L5 nerve root. The patient underwent epidural steroid injection #1 on 06/20/11 and epidural steroid injection #2 on 03/19/12. Physical examination on 05/10/12 notes range of motion remains the same. Muscle spasm along the paraspinal muscles and tenderness remain the same. Deep tendon reflexes are normal. Sensation is normal. Muscle strength is normal. Sitting and supine straight leg raising is positive bilaterally. The request for left L5-S1 epidural steroid injection was non-certified on 05/04/12 noting that the patient underwent two previous injections and reported greater than 50% pain relief, yet there is no clearly documented change in medication or function. The patient complains of back pain, but there are no gross radicular findings. The denial was upheld on appeal dated 06/14/12 noting that no additional information was provided for review. The clinician has not noted clinical evidence of significant improvement with the previous injection including objective individual

psychotherapy of pain relief of at least 50-70% for 6-8 weeks documented by increased function and decreased medication usage. The guidelines indicate that that no more than two epidural steroid injections should be performed as documented efficacy of these series of three has not been noted.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The patient has undergone two previous epidural steroid injections and reported greater than 50% subjective pain relief; however, there is no clear documentation of decreased medication usage and increased function secondary to these procedures. The submitted physical examination on 05/10/12 does not support a diagnosis of radiculopathy with normal deep tendon reflexes, sensation and muscle strength. ODG criteria for the use of ESI has not been met. Given the current clinical data, it is the opinion of the reviewer that the requested Left L5-S1 Epidural Steroid Injection #3 is not indicated as medically necessary. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)